TESTIMONY OF

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ON

"POST KATRINA HEALTH CARE: CONTINUING CONCERNS AND IMMEDIATE NEEDS IN THE NEW ORLEANS REGION"

BEFORE THE

HOUSE ENERGY & COMMERCE SUBCOMMITTEE

ON OVERSIGHT AND INVESTIGATIONS

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Testimony of
Leslie V. Norwalk, Acting Administrator
Centers for Medicare and Medicaid Services
Before the
House Energy & Commerce Subcommittee on Oversight and Investigations
Hearing on
"Post Katrina Health Care: Continuing Concerns and
Immediate Needs in the New Orleans Region"
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Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to discuss post-Katrina healthcare and the actions the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) have taken to help rebuild the Louisiana healthcare system. Challenges continue but our commitment to address them has not waned.

On August 29, 2005, Hurricane Katrina struck the Gulf Coast just east of New Orleans, near Gulfport, Mississippi. The storm's impact was significantly increased by the failure of the Lake Pontchatrain levee around New Orleans on August 30th. On September 23, 2005, Hurricane Rita made landfall east of Port Arthur, Texas. The storms caused the evacuation of over 4 million people, destroyed tens of thousands of businesses, and over 100,000 homes, required the long-term relocation of over 685,000 families, destroyed at least 8 hospitals, and were responsible for the deaths of over 1,200 people. By comparison, the four Florida hurricanes of 2004 caused the long-term relocation of 20,000 people, and at the time, set a record for that statistic.

Immediate HHS Response to the Katrina Disaster

The public health and medical situation in greater New Orleans and throughout the Gulf Coast required substantial Federal resources to prevent even further loss of life. On August 31, 2005, HHS Secretary Mike Leavitt declared a Federal Public Health Emergency for the Gulf Coast

region. This declaration (together with declarations by FEMA under the Robert T. Stafford Disaster Relief and Emergency Assistance Act) authorized CMS to waive certain requirements for such programs as Medicare, Medicaid, and the State Children's Health Insurance Program. It also allowed HHS to make grants and enter into contracts more expeditiously.

Immediate public health and medical support challenges included the identification, triage, and treatment of acutely sick and injured patients; the management of chronic medical conditions in large numbers of evacuees with special healthcare needs; the assessment, communication, and mitigation of public health risks; mortuary support; and the provision of assistance to State and local health officials to quickly reestablish healthcare delivery systems and public health infrastructures. Federal departments and agencies worked together to attempt to meet these challenges, beginning before Hurricane Katrina's landfall and continuing long after.

HHS and Department of Defense health officials collaborated with State and local health officials, maintained situational awareness for their respective agencies, and hastened the direction of medical and public health assets. National Disaster Medical System (NDMS) teams also formed an integral component of the medical response to Hurricane Katrina, collectively treating over 100,000 patients. Several agencies assigned responsibilities in the National Response Plan (NRP) under Emergency Support Function (ESF)-8 (Public Health and Medical Services), sent liaisons to the HHS Operations Center in Washington, D.C. and the HHS Secretary's Emergency Response Teams (SERTs) in the affected States. The Department of Veterans Affairs (VA) used its extensive resources to deliver care to evacuees and veterans from the affected region.

HHS deployed medical supplies and personnel to bolster State and local public health capacity in the region. It provided pharmaceuticals and other medical supplies from the Strategic National Stockpile (SNS) beginning with pre-landfall deliveries to the Superdome. By September 3, HHS had delivered 100 tons of medical supplies from the SNS to Louisiana. HHS also deployed twenty-four public health teams that included epidemiology, food safety, sanitation, and toxicology experts.

Medical and public health assets provided excellent care to thousands of displaced patients with both acute injuries and with chronic medical conditions, many of whom had multiple complex medical requirements. According to the Governors from the Gulf Region, medical and public health professionals were the true heroes of the Hurricane Katrina response. They often had to improvise and use their own initiative because the system was slow to deploy them from staging areas or failed to adequately supply them. A member of an American Red Cross inspection team, Dr. Hilarie H. Cranmer, wrote, "[i]n a little over four days, our multidisciplinary and interagency teams assessed more than 200 shelters housing nearly 30,000 people. Amazingly, in a majority of cases, the basic public health needs were being met."

Federal, State, local, private sector, and volunteer healthcare providers across the Gulf Coast took the initiative to overcome inefficiencies in the medical support system and meet their patients' needs. Louisiana State University worked with the State Office of Emergency Preparedness, Federal personnel, and responders from outside the region to turn its Pete Maravich Assembly Center into an acute care medical facility. Within a week, the facility processed approximately 6,000 patients and more than a thousand prescriptions.

Medicare and Medicaid Waivers

On August 31, 2005, Secretary Leavitt invoked section 1135 of the Social Security Act, which provides for time-limited waiver authority during certain emergencies. Under this authority, CMS proceeded to waive or modify certain Medicare and Medicaid program requirements, deadlines and timetables for the performance of required activities to ensure that Gulf Coast residents and evacuees could get the care they needed. For example, conditions of participation, certification requirements, and pre-approval requirements were waived in certain cases and for certain providers. Sanctions and penalties arising from noncompliance with agreement to speak with family members or friends also were waived. All of these actions assisted providers and the scores of individuals urgently needing their care.

CMS quickly established multiple strategies to communicate with affected providers about the changes. For instance, CMS posted question and answer documents on the CMS website; held special "Open Door Forums;" and arranged meetings with the affected states, national and state provider associations, and individual providers.

CMS also established a special 1115 demonstration waiver program to help ensure continuity of healthcare services for the victims of Hurricane Katrina, allowing States to apply to be part of a unique cooperative demonstration. The 1115 demonstration program provided Medicaid coverage to affected individuals and evacuees from areas declared by FEMA as designated counties / parishes in Louisiana, Mississippi and Alabama. Individuals in affected areas or who were displaced by Hurricane Katrina could be temporarily enrolled in Medicaid through a

simplified enrollment process for up to five months. Under the program, individuals would be enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP) and receive benefits provided by the State hosting evacuees. States could choose to charge cost-sharing to evacuees. After the period of eligibility ended under this program, the individual would need to reapply and be determined eligible for Medicaid and/or SCHIP according to the eligibility standards of the state in which they were reapplying for benefits. The Deficit Reduction Act of 2005 (DRA) also provided CMS authority to pay the non-Federal share of regular Medicaid and SCHIP expenditures in FEMA designated parishes and counties. Finally, states also were able to request inclusion in a pool to reimburse providers who incurred uncompensated care costs for medically necessary services for Katrina evacuees without other health insurance coverage for such assistance.

As of January 31, 2006, CMS had granted a total of 32 states or territories Hurricane Katrina section 1115 demonstrations. Of those 32, eight states, which are in the immediate area to the devastated areas, were also approved for the Uncompensated Care Pool. States estimated that at least 325,000 evacuee participants would be served through the programs.

Grants and Other Funding to Help Louisiana Respond and Rebuild

HHS made available more than $2.8 Billion in Katrina-related funding in Fiscal Year 2006 to help respond to the health-related needs of people affected by the disaster. This includes $2 billion for federal payments to States for healthcare assistance; $70 million in funding for healthcare related costs provided to CMS through a FEMA Interagency Agreement; a $550 million Social Services Block Grant; a $90 million Head Start hurricane-related Head Start

appropriation; and $104 million in emergency Temporary Assistance for Needy Families (TANF) funding for states affected by the Hurricane.

Healthcare Assistance

The Deficit Reduction Act (DRA) appropriated $2 billion for payments to eligible States for healthcare needs of individuals affected by Hurricane Katrina. To date, payments have been made to 32 states for a range of health-care related services and administrative costs for persons made eligible under the waivers, for uncompensated care costs, and for the State share of ongoing Medicaid and SCHIP costs for the affected areas in Louisiana, Mississippi, and Alabama.

Last month, using DRA appropriations, the Secretary also made available $160 million to Louisiana, Mississippi and Alabama for payments to hospitals and skilled nursing facilities facing financial pressure because of changing wage rates not reflected in Medicare payment methodologies. Of this, 45 percent, or roughly $71 million, went to Louisiana. In addition, on March 1st, CMS provided a $15 million grant to Louisiana for professional healthcare workforce sustainability in the greater New Orleans area. These funds are for use in the four parishes that comprise Region 1, as defined by the Louisiana State Department of Health and Hospitals; namely, Orleans, Jefferson, St. Bernard, and Plaquemines parishes. The four parishes have been designated by the Secretary as Health Professional Shortage Areas.

Funding for Katrina and Rita Victim Aid for Uncompensated Care Costs

CMS received $70 million in funding through a FEMA Interagency Agreement to support inpatient treatment provided to patients evacuated by the NDMS during Hurricanes Katrina and Rita, as well as for uncompensated care costs in four States with approved Uncompensated Care Pool waivers.

Social Services Block Grant

In FY 2006, the Social Services Block Grant received $550 million in supplemental funds for relief efforts related to the 2005 Gulf Hurricanes. Funding was provided in varying levels to all fifty states, with the majority going to Louisiana (40 percent or $221 million), Mississippi (23 percent or $128 million), Texas (16 percent or $88 million), Florida (10 percent or $54 million) and Alabama (5 percent or $28 million). These funds have been supporting initiatives to respond to human services and mental health needs of affected individuals. They also provide support to those lacking health insurance or adequate access to care, and to healthcare safety net providers.

Head Start

An additional $90 million was appropriated for Head Start as part of the FY 2006 Department of Defense Appropriation Bill. This funding was to be used to cover the costs of replacing or repairing facilities that were damaged or destroyed by Hurricanes Katrina or Rita that are not covered by insurance or FEMA, and the costs of serving approximately 4,800 evacuee children from January 1, 2006 to the end of each grantee's 2006 school year.

TANF

The Administration on Children and Families (ACF) issued funds to the hurricane damaged states in the amount of $69 million. ACF also awarded Katrina contingency funds to twenty states in the amount of $36 million. The contingency funds were provided to States for short-term, non-recurrent cash benefits for families who traveled to another State from the disaster designated States who were not receiving TANF cash benefits from another State. More than 30,000 families were assisted through these contingency funds.

Rebuilding the Louisiana Healthcare Infrastructure

HHS and CMS have been fully committed to rebuilding the Louisiana healthcare system since Katrina hit the Gulf Coast. After the storm, Secretary Leavitt and senior CMS officials made several immediate trips to the area to meet with local and state healthcare leaders to hear concerns and suggestions, to see what the federal government could do, to help lessen the hardship, and to help rebuild an antiquated healthcare system.

The Secretary made the Louisiana rebuild effort one of HHS' top priorities for America's healthcare, and developed the HHS "Guiding Principles" to direct this initiative. Fundamental to those principles was a vision, developed with extensive input from local stakeholders, under which Louisiana's "two tiered" healthcare system would be transformed into a highly functioning, sustainable infrastructure that is capable of providing high quality care, in the right setting, when needed by the population.

The Guiding Principles include a commitment to assist locally led efforts to deliver quality care and preventative health services through existing mechanisms that support personal responsibility and choice rather than funding new Federal programs or State institutions. Secretary Leavitt personally led the way in providing this assistance, traveling to Louisiana eight times since early 2006, initiating communication with key State and local, private and public leaders in healthcare. These efforts helped to encourage and facilitate formation of the Louisiana Healthcare Redesign Collaborative (the Collaborative) that would develop and implement a practical blueprint for an evidence-based, quality-driven healthcare system in Louisiana. In addition, the Secretary committed to provide personnel and to make the Department's experts available to support the work of the Collaborative.

In July 2006 the State approved legislation establishing the Collaborative as an advisory board of healthcare stakeholders that would advise the Louisiana State Department of Health and Hospitals on healthcare policy and development throughout the State. HHS marshaled its resources and made them available in fulfillment of the Secretary's commitment to the Collaborative and its efforts. The Secretary brought on a senior healthcare executive to serve as advisor for the Louisiana healthcare redesign effort, and created a new HHS project office -- the Louisiana Healthcare Rebuilding Staff (LHRS) -- to enhance communication with the State of Louisiana and key stakeholders on his behalf, as well as to facilitate the Collaborative in the development of a effective and sustainable healthcare model for the State. This new office, consisting of ten CMS employees (including four senior advisors), served as the point of entry for requests, questions and technical assistance between HHS Operating Divisions (e.g., CMS) and the State of Louisiana on healthcare reform initiatives. Four members of the LHRS staff

were deployed to the Department of Health and Hospitals' Baton Rouge office in an effort to facilitate the work of the Collaborative and communication with the Department.

The LHRS Washington staff coordinated HHS Operating Divisions and Staff Divisions involved in response to requests made by the State or members of the Collaborative, including the deployment of technical subject matter experts, the review of a Concept Paper outlining the Collaborative's plan for rebuilding, and the review of the waiver and demonstration project to assure consistency and successful completion of the process.

The Washington-based LHRS staff made over 21 separate visits to Louisiana between July 2006 and February 2007 to assist in this effort. In addition, the staff provided the Collaborative with information on all federally-operated programs in the Gulf Coast that could impact the redesign work of the Collaborative as well as available programs that would meet the needs of the Collaborative requests.

On August 23, 2006, Secretary Leavitt visited Louisiana to meet with the Collaborative and local leaders to discuss next steps toward developing a blueprint for an evidence-based, quality-driven healthcare system for Greater New Orleans. Emphasizing the importance of making specific progress on reform concepts that could be the basis of the State's submission of comprehensive, budget neutral, Medicaid and Medicare demonstration projects, Secretary Leavitt challenged the Collaborative to organize three additional workgroups to review financing alternatives, the role of community health centers in providing patient-focused care, and the role of health information

technology. At that time, the Collaborative adopted an October 20, 2006 deadline to deliver its Concept Paper for reform to HHS.

Concept Paper

The Collaborative released its Concept Paper on October 20, 2006. Since that time, CMS has been working with the Collaborative to clarify certain elements of the proposal.

In response to the Concept Paper, Secretary Leavitt again traveled to Louisiana on January 31, 2007 and discussed a number of scenarios, consistent with the underlying principles of the Collaborative, that would be budget neutral to the federal government, affordable to the State, and expand access to insurance. These scenarios were not intended to propose a specific solution, but instead to illustrate that the State has great flexibility in structuring a demonstration. HHS is encouraging the State to use that flexibility to best serve Louisiana's needs.

Secretary Leavitt has pledged support for large-scale, budget neutral Medicare and Medicaid demonstrations to bring about the Collaborative's goals, provided that they are consistent with agreed upon principles for rebuilding. We will continue to engage the State in discussions over how the demonstrations and waivers might be structured.

Conclusion

Mr. Chairman and Members of the Subcommittee, Hurricane Katrina caused severe devastation. However, the network of compassion and caring demonstrated by federal, state, and local

officials, as well as healthcare providers and others was a profound and powerful manifestation of the greatness of this country.

Providers rushed to care for those in need without considering payments or program requirements. Providers, who were personally affected by the hurricane, as well as those in areas sheltering evacuees, have provided extensive medical services under the most challenging conditions. Our role is to support their best efforts to care for seniors, people with a disability, children and families with limited means, and anyone else who needs care and has nowhere else to turn. CMS and HHS have provided an array of financial and technical assistance to Louisiana and the entire Gulf Coast in the wake of Hurricanes Katrina and Rita. HHS encouraged the formulation of an unprecedented Collaborative of healthcare leaders, and provided resources to support the Collaborative's work and its mission. Secretary Leavitt has made a personal investment of focus and energy in rebuilding the Louisiana healthcare systems, supported by continuous technical expertise offered by CMS and senior officials throughout HHS. We will continue to make that expertise available, noting that ultimately, it is up to Louisiana to decide whether and to what extent they will pursue large-scale healthcare system reforms.